

[[Table of Contents](#) | [Next Article](#)]

Shattering Stereotypes: Aging Adults Aren't Naturally Unhappy

by Susan Sample

With her white gloves, spectacles and crocheted shawl, the actress looks the part of a kindly grandmother-not a dissatisfied customer who suddenly hurls a tire through the store window. That's why the commercial has entertained television audiences for years: it shatters our stereotype of elderly women.

But only for 30 seconds. Then, quick as changing the channel, we return to the image of older adults whose faces are lined with fatigue as much as time, sitting alone as they stare out at a future that holds no promise. "In this culture, we have a perception of what it's like to grow old: life isn't a whole lot of fun," said David A. Tomb, M.D., associate professor of psychiatry at the School of Medicine.

"But when you lose a general interest in life, and other family members say, 'What do you expect? You're 82,' they're mistaken. It's ageism raising its head.

"A healthy older person remains engaged and interested in things," said Tomb, author of *Growing Old: A Complete Guide to the Physical, Emotional, and Financial Problems of Aging*. "If they're not, make sure you're not misreading their depression for a distorted view of what old is like. We have cultural stereotypes that are unhealthy and misleading."

If we could shatter our stereotypes about depression, as well as aging, we would see what is a growing public health problem: depression in those 65 years and older.

"From a public health point of view, geriatric depression is much more important than many other illnesses you hear about," said Mark Johnston, M.D., past president of the Utah Psychiatric Association "Society pays tremendous costs, financially and emotionally, for not treating it."

"Depression is one of the most treatable illnesses in any age group; 65-85 percent of people respond," said Byron D. Bair, M.D., assistant professor in internal medicine and psychiatry at the School of Medicine. "Untreated depression is a terrible illness. It does increase mortality. Suicide is more prevalent in those 65 and over than in any other age group. It's tragic when people don't get treatment."

Depression in older adults is as common as it is in younger adults: 1-4 percent of the population suffers from it. For geriatric patients, however, the statistics change significantly with location. Up to 36 percent of older adults in outpatient clinics will be depressed, while

43 percent of inpatients will be. In nursing homes, the rate of depression reaches 51 percent in those recently admitted.

Yet many of these adults aren't diagnosed. "Frankly, you never find anything if you don't look for it," said Bair, a board-certified geriatric psychiatrist. In a study of medical residents evaluating older hospitalized patients, the physicians identified depression only 15 percent of the time, although 90 percent could correctly give the criteria for diagnosing depression.

"The challenge of psychiatry is recognizing certain collections of signs and symptoms. You're looking for patterns of severity and what goes with what else," explained Johnston, who treats inpatients at the University of Utah Neuropsychiatric Institute and a growing number of older adults in his outpatient clinic. "In seniors, you must carefully sort out psychiatric illness from chronic medical problems, major depression from other conditions such as Alzheimer's, dementia and stroke-related dementia."

The two major criteria for clinical depression are a depressed mood and a loss of interest or pleasure in life for more than two weeks. Patients don't have to have both; "you can be clinically depressed without feeling depressed," noted Bair. In addition, an individual must have four of the following symptoms (three, if the patient has both major symptoms): weight loss or gain, decreased or increased appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; impaired concentration or indecisiveness; and recurrent thoughts of death and suicide, or a suicide attempt.

"'Depressed' can be a tricky word for those who don't use it professionally. It isn't just feeling sad or blue, but a set of depressive disorders," said Tomb. "Sometimes, as I meet with patients, it's very clear that we're talking at cross-purposes. They're talking about being depressed, and I wouldn't call it that."

When the patient is an older adult, the potential for miscommunication with the physician can be even greater. "Younger people report more symptoms than older ones, which there are two ways to interpret," said Bair, associate director for clinical activities at the Geriatric Research, Education and Clinical Center, Veterans Affairs Medical Center. "One, they have fewer symptoms, or, two, they report them in different ways."

"It's probably a combination," he surmised. "People who went through Woodstock have a different way of expressing their feelings than those who went through the Great Depression."

Older adults may complain of fatigue and trouble sleeping, rather than a depressed mood, because depression "isn't as socially acceptable. The meaning of 'depression' is loaded," said Bair. "Depression often is seen as a moral or spiritual weakness, not a physical manifestation of disease."

Johnston believes that some individuals with strong religious beliefs may assume that depressive symptoms are evidence of a spiritual deficiency or of living improperly. This may result in a compounding of their depression with guilt. "They tell themselves, 'If I'm living

correctly, if I'm a spiritual person, then I won't be depressed.' People need to realize that most of their religious leaders recognize the reality of mental health conditions and are supportive of professional treatment.

"We still fight the stigma that depression isn't real," said the psychiatrist. In a survey of Utahns' attitudes and beliefs about depression, researchers found that, "at the top of the list of causes were character problems and a low level of energy. Demonic possession was there, too. It was a little disturbing."

The failure to recognize depression as an illness also can be influenced by family dynamics. "We have a lot of strong emotional attitudes about our parents, about role expectations and how they should be," said Johnston. At the same time, "we get uncomfortable with role reversal," especially adult children who struggle between wanting to respect their parents' independence and feeling like they need to intervene in their parents' decisions.

"Don't automatically accept your parent's view of the world and the future-make your own assessment," Tomb advises adult children who are trying to determine whether a parent is merely sad or is depressed. A saddened widow may be "profoundly distressed," while a clinically depressed widow "may be able to be cheerful for a short while-for example, when entertaining guests. Even more deceptive may be your own perceptions of how justified your parent is in feeling unhappy."

The loss of a spouse or close friend, coupled with the pain of a chronic disease and financial worries, can lead people to believe that an older person's depressed mood is warranted. "To assume that depression makes sense is dangerous," warned Johnston. "There's an inappropriate perception that seniors should be naturally unhappy. Older people as a group are not depressed. In fact, they can be very adaptive to the losses and challenges of life."

These assumptions extend beyond the families of older adults to the population at large-including future health-care professionals. "Medical students share the same stereotypes about the elderly. Ageism is endemic to our culture," said Tomb, who lectures on development in old age as well as psychiatry. "People have to be educated to be concerned with the problems of aging. Medical schools are going out their way to introduce geriatric themes, but it takes more than that."

With people frequently having to change their health insurance and physicians, "many doctors don't have long-term relationships with their patients, so they can't read changes in their patients," said Johnston. "A patient goes to a primary care provider who tries to narrow down the list of complaints to the single most important one. But with an older patient, you want to get a thorough enough evaluation so you're not thrown off with a few symptoms. You want to look backwards for patterns of symptoms."

"The most important diagnostic information I have is longitudinal: what signs and symptoms went with this condition before? What were the social changes? You're always looking for change. From a practical point, that information can be difficult to get because of the

sheer lack of time."

Add time constraints internists' limited exposure to psychiatric illnesses in medical school and "there's a concern that a depressed individual will be diagnosed and treated only within the comfort zone of the general physician. Unfortunately, this comfort zone may not include psychiatric diagnosis and treatment," said Johnston. Likewise, specialists may focus only on one physical complaint related to their expertise. "When you have a hammer, everything looks like a nail."

"Some people dismiss depression, because they attribute it to other medical illnesses. They think of it as a reaction," said Bair. "But it should be looked at, even if it's triggered by other events. It doesn't matter what causes depression. It needs to be treated. "

When a first-degree relative suffers from depression, an individual has a 13 percent likelihood of developing the disease. "Whether that same rule applies to older folks isn't clear," said Tomb. "Depression in younger adults may be more genetically based. In older adults, it could be the result of age-induced changes in the brain's neurotransmitters."

Specific causes for depression are unknown, although studies have shown that the levels of neurotransmitters--norepinephrine, dopamine and acetylcholine--decrease with age. Researchers also have found structural changes in the brains of depressed adults age 65 and older when their magnetic resonance imaging (MRI) scans were compared to those of healthy seniors.

Psychiatrists do know that, in people 31-50 years old, untreated depression will last an average of nine to 18 months. In those over 50, it can last three to five years. Of those who experience their first episode after age 65, half will develop dementia within two to four years, according to Bair.

In contrast, "we're really good at treating depression in the elderly a variety of ways," he noted. "For mild to moderate depression, psychotherapy can be as effective as tricyclic antidepressants, improving depressive symptoms in 60-80 percent of the patients."

Older adults who receive psychotherapy, typically a series of 16-22 structured sessions of cognitive behavioral or interpersonal therapy, undergo physiological changes. "Cognitions are basically formed by synapses in the brain," explained Bair. "With depression, if you change the cognitions, you're learning new ways to think, so psychotherapy changes your neurochemistry. It may prevent relapses better than medication," he added.

When antidepressants are prescribed, older patients may be at an advantage. "They have better treatment responses at lower doses," said Johnston, who noted the "special nature" of treating geriatric patients. "You often have to start dosages at different levels than in the tables and reference materials" distributed by drug companies, and "listen carefully to patients' physical complaints."

That's especially critical when prescribing drug treatments for those suffering from severe depression. "Medications have all sorts of

side effects, and older people are more sensitive," said Tomb. "Constipation may be next to nothing for someone younger. For an 80-year-old, it can cause an impacted bowel, which presents a whole other set of problems that can be fatal."

"Speed-of-action" is another consideration. Profoundly depressed seniors often can't wait up to two weeks for medications to take effect. "Older people can't stand not moving, not drinking, not eating for very long. With severe depression, that's exactly what they do. They're at risk of dying," said Tomb. In those cases, the treatment of choice might be electroconvulsive therapy. "Patients respond rapidly-in days, not weeks."

Electroconvulsive therapy usually is administered in an operating room. An anesthesiologist injects a muscle relaxant into the patient, who becomes unconscious for several minutes. A psychiatrist places one or two electrodes on the patient's temple and delivers 20-30 seconds of electrical shock, allowing neurotransmitters to flow more freely into the patient's brain cells. One or two minutes later, the patient awakens.

"It's not at all what's in *One Flew Over the Cuckoo's Nest*. It's anything but gruesome," said Tomb. "Patients will lose memory for up to one month preceding the therapy, but over the course of treatment, they'll regain it."

"There are pieces of memory that are lost permanently, such as the minute prior to receiving the shock. But any trauma--a car accident, for example--will interrupt the consolidation of memory of the minutes preceding the event."

If major depression in older adults isn't treated, the consequences can be costly. "Medically ill patients with depression consume more health-care resources and have longer hospital stays," said Bair.

Compare \$600 for a year's supply of antidepressants to the average cost for a year in a nursing home for misdiagnosed depression, suggests Johnston. "If you spend time and money in making the right diagnosis, the care can be relatively inexpensive."

Even more costly is the loss of lives due to untreated depression. The highest rate of suicide in the United States is found in adults 65 and older; depression is the leading cause. In Utah, the rate is slightly higher, according to Bair.

Seniors also have a higher ratio of completed suicides than other age groups. For younger adults, one in every 10-20 suicide attempts will be successful. For those over 65, the ratio is one-to-one. Older adults "try more lethal ways--not more violent--using what's around," said Bair, who recalled a nursing home resident telling him how he could use a plastic laundry bag to suffocate himself.

Elderly suicide rates may be even higher, since statistics for "silent" or "passive" suicide are nearly impossible to compile. "Someone can be forgetful and not take his insulin-but he may not have taken it on purpose," said Bair. "The elderly don't say, 'I'll kill myself.' They're more likely to say, 'It would be better if I just didn't wake up.'"

Since depression is a systemic disease affecting all parts of the body, older adults often do seek medical help before they commit suicide. One study found that 75 percent of geriatric suicide victims visited a physician within one month of their death; 30-50 percent visited a physician within one week of their suicide. Most complained of physical illnesses such as congestive heart failure and chronic obstructive pulmonary disease.

"People can get trapped in a mind-set. They may be severely depressed, not seek care and feel isolated: 'I'm a worthless, useless person.' Those are the kind who commit suicide," said Johnston. "Depression can be a self-fulfilling prophecy. Physical changes can come as a result of the depression, which creates a situation where they feel like they'll never get better."

After psychiatric treatment, however, "those very people who say 'My life isn't worthwhile,' will say, 'I can't imagine I ever said that. I want to see all my grandchildren. There're books I want to read.'"

"After you see a few of these patients, you have to start looking at your stereotypes," said Johnston. "People joke about being crazy. No one wants to be labeled that way. Psychiatric disorders can be related to stresses in the environment, but they're still biologically based. They are real conditions, and it's so important that they're treated with respect."

"Being older should be a happy time of life," he said. "No one wants the stigma of being old and mentally ill. It's a double whammy."

Mapping Paths from Grief

Grief triggers nearly half of all serious depression in older adults, as well as other medical problems. To help widows and widowers map out healthy, independent lives, the University of Utah Gerontology Center at the College of Nursing is offering a new program, "Pathfinders."

"Grief and depression overlap, but they're clinically different. Grief is very specific to loss; depression doesn't have to be," said Michael S. Caserta, Ph.D., associate professor of nursing at the Gerontology Center. While the symptoms of the two can be similar—stomach problems, headaches, confusion, inability to concentrate, profound sadness—"they differ in other ways. Grief is basically an emotional and psychological reaction; depression is an illness."

Spousal bereavement in older adults has been a major focus of research at the Gerontology Center for 17 years. With funds from the National Institute on Aging, Caserta and Dale A. Lund, Ph.D., professor and center director, have studied the bereavement process and its effects on health, as well as the effectiveness of self-help groups for bereaved adults. "Pathfinders" is the most recent phase of their research.

"When we asked people who've lost a spouse what is their single greatest problem, loneliness is mentioned at least 70 percent of the time. But when we ask what is the next single greatest problem, it's

accomplishing tasks of daily living that the other spouse did: balancing the checkbook, cooking meals, changing the furnace filter," said Caserta.

For people overwhelmed by grief, neglecting these basic responsibilities can seriously affect their health. "If a widower doesn't prepare meals, his nutrition suffers, then his health suffers. Nutritional problems are the number one factor in the exacerbation of chronic diseases in older people."

Another common problem among bereaved adults is medication management. "The deceased spouse may helped manage the medications," explained Caserta. "Now, the grieving spouse lacks the concentration to remember."

Pathfinders focuses on both self-care and health promotion. During the two-hour classes, held every Wednesday morning for 11 weeks, experts discuss topics including home safety, exercise, stress management, nutrition, money management and pharmaceutical care. A grief counselor is always present. Participants, who range in age from 50-80, are given notebooks with subject outlines, and they set short- and long-term goals related to each.

"We give enough information to get people started and resources so they can follow up," said Caserta. "We've also found that they're learning from each other. Sixty-two percent of the respondents from the first set of classes said they've maintained contact with others outside of class. The classes set up a network that continues the learning beyond the classroom."

As a result, the researchers are finding that "these classes resemble self-help groups. Some classes met weekly on their own as support groups. A lot went to lunch together after class."

The third Pathfinders series will begin in March. The free classes, held at the U of U Cedar Park Continuing Education building in Murray, are open to widows and widowers age 50 and older. For more information, call the Gerontology Center at 585-9607.

[[Table of Contents](#) | [Next Article](#)]